Trichinosis

Alaska

FOR STATE USE ONLY

AK Stars #

CASE IDENTIFICATION

Name: _____
last *first* *MI*

Address: _____
Street

_____
City *State* *Zip*

Phone(s) Home: _____
Cell: _____
Work: _____

Alternate Contact: ☐ Parent ☐ Spouse ☐ Friend ☐ Household Member ☐ Other _____

Name: _____
last *first* *MI*

Address: _____
Street

_____
City *State* *Zip*

Phone(s) Home: _____
Cell: _____
Work: _____

DEMOGRAPHICS

Sex: ☐ Male ☐ Female

Hispanic: ☐ Yes ☐ No ☐ Unknown

DOB:____ / ____ / _____
(mm) (dd) (yyyy)

Or, if unknown, Age _____

Race:
☐ AI/AN
☐ Asian/Pacific Islander
☐ Black
☐ White
☐ Unknown
☐ Refused to answer
☐ Other _____

DIAGNOSTIC DATA

Clinical Data

Symptomatic: ☐ Yes ☐ No ☐ Unknown

If yes, onset on ____ / ____ / _____
(mm) (dd) (yyyy)

Check all that apply:

Eosinophilia ☐ Yes ☐ No ☐ Unk

If yes, specify absolute number or percentage

(#) _____K/uL or (%) _____

Fever ☐ Yes ☐ No ☐ Unk

Periorbital edema ☐ Yes ☐ No ☐ Unk

Myalgia ☐ Yes ☐ No ☐ Unk

Other Symptoms:

Laboratory Data

Muscle Biopsy:

☐ Positive ☐ Negative ☐ Not Done

Serological Findings:

☐ Positive ☐ Negative ☐ Not Done ☐ Unknown

Test type (specify): _____

Date of Test: ____ / ____ / _____
(mm) (dd) (yyyy)

Patient's Name →

POSSIBLE SOURCES OF INFECTION

Suspect foods consumed in the 45 days prior to illness onset:

Yes	No		Yes	No		Yes	No	
☐	☐	Bear	☐	☐	Moose	☐	☐	Seal
☐	☐	Fox	☐	☐	Pork	☐	☐	Other wild game: _____
☐	☐	Lynx	☐	☐	Walrus			

If yes to any of the above,

Date Consumed: ____ / ____ / _____
(mm) (dd) (yyyy)

Where did the meat come from? _____

Preparation:

- ☐ Not Processed
- ☐ Frozen
- ☐ Ground
- ☐ Smoked
- ☐ Unknown
- ☐ Other _____

Method of Cooking:

- ☐ Uncooked/Raw
- ☐ Fried
- ☐ Open-fire roasting/BBQ
- ☐ Boiled/cooked in stew or soup
- ☐ Unknown
- ☐ Other _____

Are there any leftovers?
☐ Yes ☐ No ☐ Unknown
If yes, have they been sent for lab testing? ☐ Yes ☐ No ☐ Unknown

Comments/details:

CASE-CONTACT MANAGEMENT AND FOLLOW-UP

Number of others who consumed suspected meat/meal: _____

Name	Ill	Symptom Onset (mm/dd/yyyy)	Phone
	☐ Yes ☐ No ☐ Unk		
	☐ Yes ☐ No ☐ Unk		
	☐ Yes ☐ No ☐ Unk		
	☐ Yes ☐ No ☐ Unk		

(If there are more contacts, please use the back of this form)

Does the case know about anyone else with a similar illness? ☐ Yes ☐ No ☐ Unk

If yes, give name(s), onset date(s), contact information, and additional pertinent details.

Case education provided? ☐ Yes ☐ No ☐ Unk

Completed by: _____ Phone: _____ Date: _____